BARRY WASSERMAN, M.D.
INSURANCE REFERRAL WAIVER

I, _____ am aware that my insurance carrier,

_____, requires that, prior to my appointment, I obtain a valid referral (dated no later than today) from my Primary Care Physician for any office visits, testing and or other services provided to me by Dr.Wasserman.

I have been informed that if Dr. Wasserman does not receive a referral for the services being provided today, I am aware that I am fully responsible for the total charges incurred for those services.

Patient Name_____

Patient Signature_____ Date_____